Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004686	A. BUILDING _____ B. WING _____	C 07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON HOUSE	2116 BUTLER RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00093375. Complaint IN00093375 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: July 19, 20, 2011 Facility Number: 004686 Provider Number: 004686 Aim Number: N/A Survey team: Sheryl Roth RN, TC Sue Brooker, RD Census bed type: Residential: 35 Total: 35 Census payor type: Other: 35 Total: 35 Sample: 4 Hamilton House was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00093375. Quality review completed 7/21/11 Cathy Emswiller RN	R 000		